



COUNSELING MODEL DEVELOPMENT BASED ON ANALYSIS OF UNWANTED PREGNANCY CASE IN TEENAGERS

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Abstract

Teenagers who experience unwanted pregnancies are increasing. The number of client that access the Unwanted Pregnancy counseling services in IPPA Central Java in the year 2006 (94 clients), 2007 (91 clients), 2008 (95 clients), 2009 (68 clients), 2010 (157 clients), 2011 (98 clients), and 2012 (83 clients). Related to that data, 31% of clients were referred Haid Induction (HI), 3% refer shelter, and 66% continue the pregnancy and there were not identified. This research conducted in 2014 used quantitative-qualitative approach which aimed to develop a model of counseling after mapping the case. Respondents were 5 Unwaned Prenancy counseling clients selected based on the final decision of counseling. From the research developed counseling model for teenage which should have an easy procedure, complete services, opening hours accordingly, no discrimination, respect privacy, provide pro choice, and low prices. Services consists of counseling, contraception, safe abortion, treatment of STIs, information center counseling and HIV testing, gynecological, prenatal and postnatal services, as well as the services of victims of gender based violence and sexual abuse.

Introduction

Reproductive health issue has been under the spotlight ever since the issue was raised at the International Conference on Population and Development (ICPD), in Cairo, Egypt, in 1994 (Panchauri, 2013). Population control policies then shifted to a broader range, including reproductive health needs for both men and women throughout the life cycle, including their reproductive rights, gender-equality and equity, women empowerment and the handling of gender-based violence, and also men's responsibilities pertaining to reproductive health.

Risky sexual intercourse among adolescents would lead to Unwanted Pregnancy

(UWP). UWP occurs due to several factors such as sociodemographic factors (poverty, sexually active and lack of contraception usage, mass media), disharmonized family (family relationships), developmental status (lack of thought about the future, want to experience, attention-seeking), usage and abuse of drugs (Rosyeni, 2013). Other factors that contribute include incomplete and inaccurate knowledge about the process of pregnancy and the prevention method, contraceptive failure, and being a rape victim (Kusmiran, 2011). Increasingly permissive attitudes would also affect teenagers' sexual behavior that could lead to UWP (Azinar, 2013). UWP has physical, psychological and social impact. Pregnant

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teenage students would face responses from two parties. The first is from the school, who usually responded unfavourably such as by expelling the pregnant student. Expelled students would lose the opportunity to work and, leaving the options of working as a single parent or going through an unplanned early marriage (Pachauri, 2011; Gyan, 2013).

Based on the Indonesian Teenage Survey on Reproductive Health (SKRRI) 2002-2003, it was recorded that teenagers who had a friend who already had sex at the age of 14-19 years comprised 34.7% of women and 30.9% of men, while those who have friends who already had sex at the age of 20-24 years comprised 48.6% of women and 46.5% of men.

The number of UWP clients who accessed PILAR PKBI counseling service in Central Java varies from year to year. There were 94 people in 2006, 91 people in 2007, 95 people in 2008, 68 people in 2009, 157 people in 2010, 98 people in 2011, and 83 people in 2012. Counseling data in PILAR PKBI is still limited because the instrument used for counseling guidance could only explore the characteristics of the client but is unable to explore the data of the spouse, parents, and the sociodemographic status of the client (Hermawan, 2012). UWP counseling conducted by PKBI is not optimal because the number of adolescents who accessed it was low, and there is no follow up after a decision was taken.

Based on the description above, this study conducted a data mapping of UWP clients who had accessed counseling services in PKBI. Mapping or analysis of specific social situations is often considered as a method to encourage the participation of people who experienced the same situation to develop a specific community development program by establishing the understanding between group members on the issues. According to the data, in 2010 31% of UWP clients were referred for abortion, 3% were referred into shelters, while 66% had no record of their final decision. This can be caused by the limitation in the existing counseling model in PKBI. Therefore, we develop UWP counseling model that was started by mapping or case analysis in PKBI Central Java.

The purpose of this research are: 1) To

develop counseling model based on analysis of unwanted pregnancy (UWP) cases in Semarang, 2) To analyze cases of UWP among adolescent in Semarang in the year 2008-2012, 3) To analyze the counseling process of UWP cases at PKBI Central Java and, 4) To develop UWP counseling model.

Methods

This study consists of 3 steps. First step is a descriptive study with quantitative approach, the second step is qualitative approach, and the last step is development of a model based on the findings from the first and second study. In the first study, quantitative approach was used to picture an event that occurred. Descriptive design was chosen to picture the events studied and then described the events as it happened, hence intervention and variable manipulation was not needed. Quantitative approach is an approach that produces result from statistical procedure or other mathematical processes. We want to know the research problem without manipulating research setting, understand the situation as it is happened, without direct contact. This study would try to analyze the data characteristics and describe the UWP cases in Semarang based on respondents characteristic (age, educational status, and job), parents' job, sex partner characteristic (age, educational status, and job), sociodemographic status (origin and living status), and UWP case trend in Semarang, using secondary data from UWP clients in PKBI Central Java. The second step used a qualitative approach with case study design to gain in-depth information about the experiences and behaviors of those who experienced UWP, counseling process, until the decision-making process. The third step of this study was developing a counseling model based on the findings of the first and second studies.

The population in the first step is clients of PILAR PKBI Central Java from 2008 to 2012. In the second study, a qualitative approach was used; hence we conducted in-depth interviews to counselors, clients, and parents of clients as informants.

The primary data in this study was obtained from in-depth interviews with respondents consisting of 5 UWP counseling clients selected after considering the final decision post-counseling, 2 counselors

triangulation respondents, and 2 parents of the clients.

The secondary data was obtained from adolescent unwanted pregnancy (UWP) case information in Semarang who were clients of PKBI Central Java from 2008-2012 which had were then analysed and presented as descriptive data analysis. Qualitative data which was the result of interview with counselor, UWP client in PKBI Central Java, and parents were analyzed using Miles and Huberman analysis. This analysis uses three components of analysis, namely Data Reduction, Data Presentation, and Conclusion Withdrawal. The counseling model development was conducted after the quantitative and qualitative research data were analyzed. The data was used to develop a model appropriate for the needs and expectations of counselors, clients, and parents.

Results and Discussion

Based on the secondary data, the age frequency distribution of respondents who experienced an unwanted pregnancy event (UWP) from 2008-2012 was at least 11 years old in 2012, 13 years old in 2009, while 15 years old in the years of 2008, 2010, and 2011. The maximum age of respondents who experienced a UWP from 2008-2012 was 24 years old. The age category of the majority of respondents

who experienced UWP from the year 2008-2012 was late adolescents, not early teenage.

The definition of adolescents used in this study were all adolescents aged 15-24 years old, while adolescents selected as respondents were those who had out of marriage pregnancy or UWP and was counseled in PILAR PKBI Central Java.

Based on the age of respondents, UWP mostly occurs in adolescence. Pregnancy in adolescence increases the risk of maternal and infant death 2-4 times higher than mothers aged 20-25 years (Tusiime, 2015). The other risk is when the pregnant adolescent decides to end UWP through abortion or IH. Teenagers who experience UWP at school age are at risk to be expelled, hence threatening their welfare because of lack of education. Today, not many schools are willing to enroll students who have experienced UWP. However, advocacy related to such issue are ongoing (Nasution, 2012).

The level of education were elementary school, junior high, senior high, and diploma/undergraduate. The majority of UWP clients in PILAR PKBI Central Java from 2008-2012 had an education level of senior high while those having other levels of education in was 68% in 2008, 65.5% in 2009, 84.2% in 2010, 69.4% in 2011, and 55.3% in 2012.

Table 1. Frequency Distribution of Cases of UWP Based on Age of Informant

Details	Year				
	2008	2009	2010	2011	2012
Total	25	100	29	100	19
Minimum	15	13	15	15	11
Maximum	24	24	24	24	24
Mean	19,08	19,62	18,95	18,64	18,30

Source : Secondary data from the result of the study

Table 2. Frequency Distribution of UWP Cases Based on Education Level

Category	Year									
	2008		2009		2010		2011		2012	
	f	%	f	%	f	%	f	%	f	%
No School	0	0	0	0	0	0	0	0	0	0
Elementary	0	0	0	0	0	0	2	5,6	1	3,7
Junior High	6	24	6	20,7	3	15,8	3	8,3	9	33,3
Senior High	17	68	19	65,5	16	84,2	25	69,4	15	55,6
Diploma/college	2	8	4	13,8	0	0	6	16,7	2	7,4
Total	25	100	29	100	19	100	36	100	27	100

Source : Secondary data from the result of the study

In this study, 1 respondent was a senior high school student, 2 respondents were in college, and 2 respondents were already working. Increased mobility of adolescents and the higher chance for teenagers to study, work, and live separately from their parents were one of the factors that increase the incidence of sex before marriage.

The place of origin is the respondent's identity according to the address where he/she lives. The highest UWP cases based on place of origin from 2008-2012 was respondents who lived in Ngaliyan with 14 cases from 2008-2012.

There were 3 respondents from rural areas and 2 respondents from urban areas. This shows that sexual behavior did not happen only in the urban area. One of the cause is the rapid development of technology, information, and social media. Children or teenagers can easily access pornographic media either from electronic or printed source. This increase is not followed by increased knowledge on reproductive health (Speizer, 2015).

The result of the study showed that the majority of respondents' sexual partner that resulted in UWP was their boyfriend. This happened from 2008 to 2012 with the highest

number of cases in 2011 (36 cases).

Similar to the study's respondents, the five respondents said that sexual relationship with their boyfriend was the cause of unwanted pregnancy. As social creatures living in modern civilization, teenagers cannot be prohibited from dating dan having sexual intercourse. Dating is normal a behaviour, however nowadays the relationship between man and woman is viewed more openly. It is important to realize that dating among teenagers would be an influence and initiative to have sexual intercourse.

Dating is considered as the entrance into deeper relationship. Sexual intercourse before marriage is considered as a form of closeness between two people in love. Sometimes teenagers could be carried away to have sexual intercourse with their boyfriend in the absence of clear restriction in dating, or it was done unaware or unplanned (Leerlooijer, 2013; Hewageegana, 2014).

In this study, all of the respondents said that the one who initiated to have sexual intercourse is their boyfriend. They believed their boyfriend would be their husband someday, while the boyfriends thought that

Table 3. Frequency Distribution of Unwanted Pregnancy Cases by Place of Origin

Place of Origin	Year									
	2008		2009		2010		2011		2012	
	f	%	f	%	f	%	f	%	f	%
Banyumanik	2	8	3	10,3	2	10,5	0	0	1	3,7
Candisari	1	4	2	6,9	3	15,8	3	8,3	0	0
Gajah Mungkur	1	4	3	10,3	1	5,3	3	8,3	0	0
Gayamsari	3	12	0	0	0	0	3	8,3	4	14,8
Genuk	0	0	2	6,9	0	0	1	2,8	4	14,8
Gunung Pati	1	4	1	3,4	0	0	1	2,8	1	3,7
Mijen	0	0	1	3,4	1	5,3	4	11,1	0	0
Ngaliyan	3	12	6	20,7	1	5,3	9	25	3	11,1
Pedurungan	2	8	3	10,3	1	5,3	4	11,1	3	11,1
Semarang Barat	1	4	1	3,4	1	5,3	1	2,8	2	7,4
Semarang Selatan	2	8	0	0	1	5,3	1	2,8	2	7,4
Semarang Tengah	1	4	0	0	0	0	0	0	2	7,4
Semarang Timur	0	0	2	6,9	1	5,3	4	11,1	2	7,4
Semarang Utara	2	8	3	10,3	0	0	1	2,8	0	0
Tembalang	2	8	2	6,9	1	5,3	1	2,8	1	3,7
Tugu	4	16	0	0	0	0	0	0	1	3,7
Total	25	100	29	100	19	100	36	100	26	100

Source : Secondary data from the result of the study

his girlfriend would not necessarily be his wife someday because they were still exploring. If they were not matched, the boyfriends would easily leave his girlfriend even if they already had sexual intercourse. Then women were the ones experiencing a huge loss.

Based on study result, PILAR PKBI counseling clinic, Jawa Tengah, already achieved some criteria of youth friendly services. From the providers' side, PILAR PKBI counseling clinic at Central Java had clinical staffs who had received special training to respect and be friendly with teenagers and to respect their privacy. Duration of counseling in the clinic was also deemed sufficient for developing an interaction between the counselor and the client. From the clinical facilities and program design aspect, the clinic was easily accessible because it was near to the city, Jl. Jembawan Raya No.8 – 12 Semarang. The counseling fee was affordable. There was no gender discrimination, both teenage boys or girls were well-served. The service hour was sufficient and appropriate to teenagers' needs. The interior and exterior design of the clinic provided comfort and ensure that their privacy would be safeguarded and also had a special transit room for media communication, education, and information for teenagers. PILAR PKBI counseling clinic, Central Java, also provided service for various teenage reproductive health issues such as unwanted pregnancy counseling, STI service, and HIV – AIDS.

Some aspects that need to be improved in PILAR PKBI counseling clinic, Central Java, were the ease to refer to a hospital when needed. This could be done by cooperating with other health facilities in Semarang City or other cities in Jawa Tengah. Teenagers' involvement in designing and further developing the counseling clinic is also needed because those who will access this services are teenagers. Routinely providing group discussion on teenagers' issues could also be done. Improving access to information, consultation, and services provided by the clinic could improve the quality of service. Improving promotive efforts related to counseling services is needed because there were many teenagers who do not know about the services. Promotional efforts can be done through social media that is currently being

used by many teenagers.

It is not easy to build a reproductive health service which is easily accessible to teenagers. The problems encountered include lack of adolescent-friendly medical staff, lack of funds to create an ideal service, and barriers of value from the surrounding community due to their cultural construction (Ceylan, 2009). There were also policy barriers from the government, such as difficulty to obtain permits to establish a clinic for teenagers. Despite the constraints, establishing programs that meet teenagers' needs for information and reproductive health services should be a positive challenge (Situmorang, 2011).

It can be formulated that the role of counselor are as preventive that helps clients maintain or prevent the occurrence of problems and curative/corrective which is helping clients solve the problem at hand (King, 2013; Wieler, 2016). Preservative, helps people improve the situation from problematic into a good state (problems solved) and that state of good maintained for as long as possible. Developmental, helping client maintain a good situation and, whenever possible, improve the situation, so that it no longer cause problem for them (Desirae, 2007; Hurlock, 2009).

According to International Planned Parenthood Federation (IPPF), the following are mandatory services in adolescent-friendly clinics. First, counseling services. A truly adolescent-friendly clinic should provide adequate counseling to its clients. Teenagers can choose their counselor, male or female, and counselor should be willing to discuss about health, friendship, dating, and sexual relationship.

Second, contraceptive services. Access to contraceptive is a mandatory service in adolescent-friendly services. However, contraceptive services cannot be provided without proper regulations. Before accessing the service, the client should be counseled to provide a good understanding of how to use contraception, why contraception is necessary, and the risks of sexual behavior. After receiving counseling services, the clinic need to provide contraceptives such as birth control pills, condom, injections, and/or IUD. If needed, the clinic should have emergency contraceptions.

Third, safe abortion services. Safe abortion services is still a controversial issue, but it is a serious problem. According to World Health Organization (WHO) data, 11 – 14% of maternal deaths in Indonesia are caused by unsafe abortions. Many women feel compelled to have an abortion because they had an unwanted pregnancy. This happens because of lack of access to contraceptive services, and the absence of education that warns teenagers about the risk of sexual behavior. Therefore, safe abortion should also be provided by clinics. Beside. Adolescent-friendly clinics should provide the choice of abortion methods, pre- and post-abortion counseling to clients, to ensure that clients make the right decision and would not be traumatized afterwards.

Fourth, sexually transmitted infections (STIs) and reproductive tract infections (RTIs) care. STIs and RTIs are serious, but easily treated with the appropriate medications and therapies. In addition to providing tests for STIs and RTIs, a comprehensive clinic should provide at least one method of treating STIs and RTIs, while providing condom as contraception tool that can prevent STIs and RTIs.

Fifth, VCT service for HIV. An adolescent-friendly clinics should provide counseling before and after HIV test, laboratory test to find out if the client is infected with HIV

virus, as well as information about condom to prevent potential HIV dissemination from the client to others.

Sixth, gynecological services. Gynecologist or women reproductive health specialist must be present in every clinic. In addition to providing various genital and breast examination, a good clinic should provide pap smear test or other methods to detect cervical cancer.

Seventh, Prenatal and Postnatal services. Prenatal (before delivery) and postnatal (after delivery) services must be provided by reproductive health clinic and adolescent-friendly clinic. In addition, the clinic also needs to provide an accurate and affordable pregnancy test.

Eighth, service for sexual- and gender-based violence victim. Besides identifying the victim of gender- and sexual-based violence, clinics should be able to handle or introduce victims to other parties who can handle violence cases; such as psychologists, authorities, etc.

In addition, referral services for teenage-friendly unwanted pregnancy counseling was developed in this study. Developing adolescent-friendly counseling requires cooperation from many parties. A figure of developing adolescent-friendly counseling referral service model is shown below:

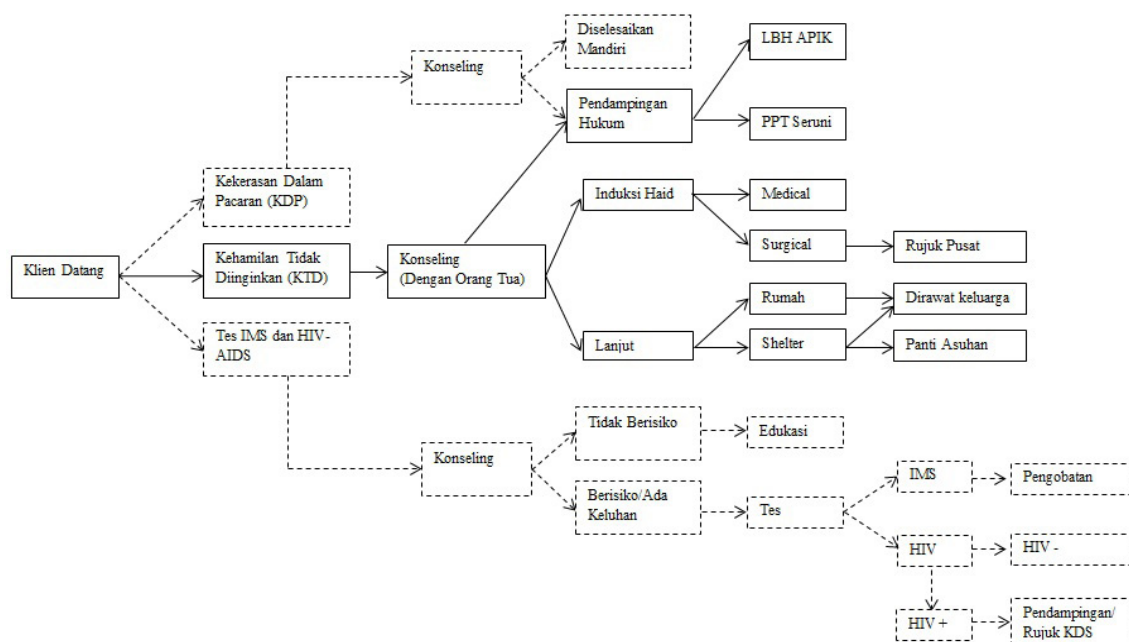


Figure 1. Counseling Model Based on Unwanted Pregnancy Case Analysis

Based on Figure 1, it can be seen that after the client arrives, counseling services will be given in the presence of their parents. After counseling, the client will decide whether to choose menstrual induction (MI) or continue the pregnancy. If the client chooses menstrual induction, then the client will receive two alternative methods, medical abortion (MA) or surgical abortion (SA) in PKBI center clinic. If the client chooses to continue the pregnancy, there are two alternatives which is continuing at home or at a shelter. After the baby is born, there are also two alternatives, cared by the family or submitted to a shelter. For clients in need of legal assistance, there are NGOs that could provide assistance i.e. APIK Legal Aid Institute (LBH APIK) and Intergrated Service Center (PPT Seruni).

With the development of a comprehensive counseling model, clients would be able to find the most feasible alternative solution, hence solving the problems of unwanted pregnancy and unsafe abortion.

Conclusion

Unwanted adolescent pregnancy cases in Semarang City during 2008 – 2012 were 55 cases in average, and the average of client's age was 19 years. The average level of education among cases of unwanted adolescent pregnancy was senior high school, amounting to more than 55% every year. The highest case of unwanted pregnancy came from Ngaliyan with a total of 14 cases. More than 78% of the teenagers had sexual intercourse with their boyfriend.

The unwanted pregnancy counseling process at PKB was performed by trained counselors with experience in unwanted pregnancy counseling. The main reason why clients accessed the counseling service at PKBI was for abortion. On average, clients had 1-2 sessions of counseling before making a decision. The follow-up after decision-making is still limited.

According to the result of interviews and adolescents-friendly services standards compiled by the National PKBI, Unwanted Pregnancy Counseling Model for teenagers should have easy procedures, comprehensive services, appropriate service time, free of discrimination, respecting teen privacy, providing an open option, and cheap. Services

that should be available at clinics are counseling services, contraceptive services, safe abortion, STI and RTI care, counseling information center dan HIV testing, gynecologist, prenatal and postnatal services, and services for sexual- and gender-based violence victim.

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